Seborrheic dermatitis was also common ($n = 43$, 21.8%) (Table II).

Other comorbidities included Vitamin D deficiency ($n = 43$, 21.8%), hyperlipidemia ($n = 39$, 19.8%), obesity ($n = 35$, 17.8%), gastroesophageal reflux disease ($n = 32$, 16.2%), and anemia ($n = 24$, 12.2%). Psychiatric comorbidities including depression, anxiety, or sleep disorders were identified in 14.2%, with absence of documented history of suicide attempts (Table II).

Our study shows that H/L patients with AA have a similar average age at diagnosis, slight female predominance, and increased atopy compared to the general population in recent AA studies.[1,2] Male H/L patients with AA were younger than female at diagnosis ($P = .01$, Table I). Interestingly, the most common autoimmune comorbidity in H/L was rheumatoid arthritis, compared to thyroid disease in Black patients[1] and overall patients with AA.[2,3] This finding may be a reflection of a larger trend, as rheumatoid arthritis in the H/L population has been on the rise.[4] Thyroid disease in our H/L cohort with AA was slightly higher than the 4.8% reported in the general Hispanic population.[5] Atopy and hypertension were less common in H/L than in Black patients[1] or patients with AA overall, but gastroesophageal reflux disease was more prevalent.[3]

A strength of our study is that most patients were evaluated by a hair specialist on the study team (NAM). Limitations include the small sample size, lack of a control group, and that patients may have received additional healthcare outside of our center. The study findings increase the current knowledge of the demographics of H/L patients with AA, and heighten awareness of associated inflammatory comorbidities, in particular rheumatoid arthritis.

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**Conflicts of interest**

None disclosed.

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## Clinical and pathological features of cutaneous manifestations in VEXAS syndrome: A multicenter retrospective study of 59 cases

*To the Editor:* VEXAS (vacuoles, enzyme E1, X-linked, auto-inflammatory, somatic) syndrome is a late-onset autoinflammatory condition due to myeloid-restricted somatic mutations in the ubiquitin-activating enzyme 1 gene.[1] Skin involvement seems to be one of the most common symptoms,[1-4] and may be the first manifestation of VEXAS syndrome.[5] However, most studies have been performed in non-dermatology departments with no centralized review of cutaneous involvement and limited numbers of patients.[4,5]

In this multicenter nationwide retrospective study, all 59 patients from the French VEXAS study group (NFVS) database with photographs of skin lesions and/or skin biopsies available for centralized review on June 15, 2021, were included. This study received approval from our Institutional Review Board (CLEP Decision no.:AAA-2021-08040).

**Table I.** Clinical characteristics of skin involvement ($n = 37$)

| | |
|---|---|
| Lesion description | |
| Lesion type | |
| Maculopapules and nodules | 37 (100%) |
| Pustules | 5 (13%) |
| Vesicles/bullae | 4 (11%) |
| Livedo | 6 (16%) |
| Reticularis | 3 (8%) |
| Racemosa | 3 (8%) |
| Thickness of pattern <1 cm | 3 (8%) |
| Lesion shape | |
| Round/nummular | 36 (97%) |
| Arcuate/annular | 12 (32%) |
| Lesion color | |
| Pink | 28 (76%) |
| Red | 27 (73%) |
| Violaceous/purpuric | 18 (49%) |
| Lesion size | |
| <1 cm | 29 (78%) |
| ≥1 cm | 29 (78%) |
| Both | 21 (57%) |
| Number of lesions | |
| ≥10 | 33 (89%) |
| <10 | 4 (11%) |
| Localization | |
| Trunk | 30 (81%) |
| Arms | 32 (86%) |
| Legs | 31 (84%) |
| Face | 11 (30%) |
| Pathergy | 5 (13%) |
| Cutaneous symptoms | |
| Pain | 13 (35%) |
| Pruritus | 9 (24%) |
| Evolution of skin lesions | |
| Flare/remission periods | 30 (81%) |
| Frequency of flare-ups (times/y, median [IQR]) | 6 (2-12) |
| Duration of flare-ups (d, median [IQR]) | 9.8 (7-10) |
| Permanent | 4 (11%) |

*IQR*, Interquartile range.

The median age at first symptoms was 68 years (interquartile range: 61.5-73) and 97% patients were male (Supplementary Table I, available via Mendeley at https://doi.org/10.17632/zpz5h43c4w.1). Cutaneous involvement was the first symptom for most patients (63%). The most common initial hypothesis for the skin involvement was Sweet syndrome (47%). Among the 37 patients with available photographs (Table I), all showed round shaped maculopapules of various sizes (57% showed both < and ≥1-cm lesions), mostly pink/red (76%), often numerous (89% of patients had ≥10 lesions), on the trunk (81%), the limbs (85%), and the face (30%). Lesions were arcuate in approximately one-third (32%, Fig 1). Other cutaneous lesions included livedo (16%), pustules (13%), and injection-site reactions (pathergy, 13%) (Supplementary Fig 1, available via Mendeley at https://doi.org/10.17632/zpz5h43c4w.1). Skin lesions were typically characterized by periods of flare and remission (81%). Among the 43 patients with available biopsies, most (89%) patients had infiltrates of the superficial dermis. The infiltrates consisted of immature myeloid cells and variable proportions of mature neutrophils, lymphocytes, and histiocytes, which led to retaining the diagnosis of neutrophilic dermatosis rich in immature myeloid cells in 77% patients (Supplementary Table II, available via Mendeley at https://doi.org/10.17632/zpz5h43c4w.1). Leukocytoclasia was present in 63% patients; however, no vasculitis was found. Few patients showed vessel thrombosis (venous in 3 patients, capillary in 2 patients, and arteriolar in 1 patient). Immunostaining revealed the presence myeloid precursors with overlapping expression of CD68 and MPO (myeloperoxidase) in 88% (Supplementary Fig 2, available via Mendeley at https://doi.org/10.17632/zpz5h43c4w.1). Cytological analysis was performed in 30 cases to better characterize the myeloid precursors. They were classified as metamyelocytes in 52%, as myelocytes in 42%, and as band neutrophils in 26%.

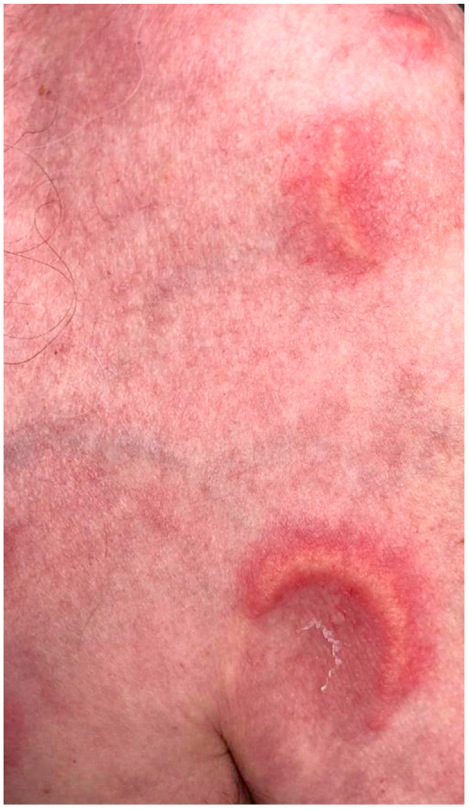

**Fig 1.** Arcuate papules in VEXAS (vacuoles, enzyme E1, X-linked, auto-inflammatory, somatic) syndrome.

Overall, the spectrum of cutaneous lesions of VEXAS is characterized by a wide heterogeneity. About one-third of patients showed lesions with an arcuate shape (Fig 1), which we believe is suggestive of the diagnosis. Pathological infiltrates typically consisted of superficial perivascular and periadnexal lymphohistiocytic infiltrates with immature myeloid cells and displayed signs of dysplasia in most cases. In previous studies, vasculitis was frequently reported (25%-70%),[1,3-5] but this rate has probably been overestimated. Indeed, despite the high prevalence of leukocytoclasia, we found no vasculitis after centralized review. The main limitation of our study is its retrospective design.

In conclusion, VEXAS syndrome should be considered in patients ≥60 years with general symptoms, systemic inflammation, and with skin infiltrates showing neutrophilic dermatosis with immature myeloid cells.

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**Conflicts of interest**

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## High compliance with National Comprehensive Cancer Network guidelines and no local recurrences for patients receiving Mohs micrographic surgery for Merkel cell carcinoma: A single-center retrospective case series

*To the Editor:* National Comprehensive Cancer Network (NCCN) guidelines for Merkel cell carcinoma (MCC) recommend excision of the primary tumor and sentinel lymph node biopsy (SLNB) for staging. NCCN guidelines include Mohs micrographic surgery (MMS) as an excision technique and recommend sending a debulking excision for staging with paraffin-embedded vertical permanent sections.[1]

**Table I.** Patient demographics and case characteristics for patients with Merkel cell carcinoma treated with Mohs micrographic surgery ($n = 30$)

| | |
|---|---|
| Mean age, y (SD) | 72.3 (16.0) |
| Female sex, *n* (%) | 16 (53.3) |
| Immunosuppressed, *n* (%) | 2 (6.7) |
| Tumor location, *n* (%) | |
| Cheek | 8 (26.7) |
| Nose | 7 (23.3) |
| Periorbital | 5 (16.7) |
| Forehead | 3 (10.0) |
| Ear | 3 (10.0) |
| Extremities (excluding hands/feet) | 2 (6.7) |
| Temple | 2 (6.7) |
| Primary lesion, *n* (%) | 26 (86.7) |
| Pre-op lesion size in cm, *n* (%) | |
| 0.00-0.49 | 4 (13.3) |
| 0.50-1.00 | 10 (33.3) |
| 1.01-2.00 | 10 (33.3) |
| >2.00 | 6 (20.0) |
| Post-op lesion size in cm, *n* (%) | |
| 0.50-1.00 | 1 (3.3) |
| 1.01-2.00 | 6 (20.0) |
| 2.01-5.00 | 18 (60.0) |
| 5.01-10.00 | 5 (16.7) |

*post-op*; Postoperative; *pre-op*, preoperative; *SD*, standard deviation.